healthscrutiny east sussex

East Sussex Health Overview and Scrutiny Committee (HOSC)

East Sussex Healthcare NHS Trust (ESHT) – Quality Improvement in Response to the 2015 Care Quality Commission (CQC) Inspections

Final HOSC report

24 March 2016

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Chair's Foreword

This Health Overview & Scrutiny Committee (HOSC) Review Board was established in response to the critical Care Quality Commission (CQC) report on East Sussex Healthcare NHS Trust (ESHT) services to the residents of East Sussex, and has been delivered in an environment where several other agencies have also been conducting oversight of ESHT.

During the period of this Review Board we have seen a significant re-profiling of the management of ESHT. Not only did the Chairman and the Chief Executive resign from their posts, with a new Chairman and a new Chief Executive appointed to take forward a new culture in ESHT; but also a number of Non-Executive and Executive Directors have been changed.

I would like to give thanks to all committee members of HOSC for their careful and diligent scrutiny of the various aspects of this review, and for applying their experience and particular interests in examining the performance and behaviour of the different aspects of ESHT provision.

I would also like to give thanks to the management and staff of ESHT who have studiously explained and demonstrated the changes and improvements being implemented to tackle the criticisms from the CQC report, and the implementation of the ESHT Quality Improvement Plan.

This Review Board report is provided not only to give feedback to ESHT on our findings, observations, and recommendations, but also to provide the CQC and the NHS Trust Development Authority (now NHS Improvement) with the HOSC's views on the provision of healthcare to the residents of East Sussex, and also our view of the direction of travel of ESHT.

This Review Board report will also provide the HOSC with a baseline against which we will take forward our own work programme of scrutiny over the coming year.

It is hoped that our deliberations will give a degree of assurance to the residents of East Sussex that the HOSC is representing the views and is acting on their behalf in seeking to hold the NHS to account.

Cllr Michael Ensor
Chair
East Sussex Health Overview and Scrutiny Committee

Recommendations

Recommendation about the general potential for sustained quality improvement at East Sussex Healthcare Trust (ESHT)

1) In the HOSC's view, ESHT's interim management team has shown that it understands the need for, is committed to, and is capable of delivering, sustained organisational improvement.

Recommendation about monitoring ESHT quality improvement

2) The HOSC will continue to monitor ESHT quality improvement, particularly in terms of: sickness absence rates, bullying and harassment, complaints, incident reporting, and staffing and recruitment.

Recommendation about ESHT capital projects

3) ESHT should report to the HOSC confirming whether funding for the promised Better Beginnings capital works and for any works that form part of the Quality Improvement Plan (QIP) has been secured. Should the predicted NHS or corporate funding no longer be available, ESHT should set out its alternative plans for securing key projects.

Recommendation about surgical bed capacity

4) ESHT needs to develop a strategy to deal with general medical capacity demands without impacting on the performance of the trust's surgical units.

Recommendation about leadership

5) ESHT is asked to report to the HOSC on its plans for board development in response to the CQC's criticisms of trust senior leadership.

Recommendation about strategic risk management

6) ESHT is asked to report to the HOSC on what it is doing to ensure that the trust's system of strategic risk management is fit for purpose.

Recommendation about hospital discharge

7) ESHT is asked to report to the HOSC on what it is doing to ensure that hospital discharges are not unduly delayed by waits for take-home medicines or other factors within the control of the trust.

Recommendation about incident reporting and complaints

8) ESHT is asked to report to HOSC on the measures it is taking to cross-reference the trust's incident reporting and complaints data.

Recommendation about seven day working

9) ESHT is asked to report its plans to move to a seven day working model to the HOSC.

Introduction

Background

1. The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It inspects and rates NHS provider trusts in terms of five quality domains: ***safe, well-led, caring, effective*** and ***responsive***. Key service areas at each trust hospital and clinical unit are scored as either ***outstanding, good, requires improvement*** or ***inadequate*** against each of these domains. In its reports on individual trusts, the CQC also publishes a headline rating for each domain as well as overall ratings for each trust hospital and for the entire trust.

2. The CQC inspected East Sussex Healthcare NHS Trust (ESHT) in September 2014, and published its inspection reports on the 27th March 2015. The reports rated ESHT inadequate in terms of the safe and well-led domains; requires improvement in terms of effective and responsive; and good in terms of caring. Overall, ESHT was deemed inadequate.

3. The CQC undertook a follow-up inspection in March 2015, and these inspection reports were published in September 2015. The trust was again deemed to be inadequate and was subsequently placed in special measures by the Trust Development Authority (TDA). The TDA is the NHS body responsible for overseeing all NHS trusts which are not foundation trusts. The CQC inspection reports can be found here: **www.cqc.org.uk/provider/RXC**

4. In May 2015, the East Sussex Health Overview & Scrutiny Committee (HOSC) held a special meeting to question ESHT, the CQC and the TDA about the initial inspection findings. HOSC members were concerned by the failings identified in the inspection reports; and also worried by the attitude of ESHT's most senior leaders, who appeared reluctant to acknowledge the scale of the challenge identified by the CQC. In consequence, HOSC members agreed a motion calling for the resignation of the Chair and Chief Executive of ESHT. Minutes and webcasts of all East Sussex HOSC meetings are available here: **www.eastsussexhealth.org/**

5. In June 2015, HOSC members decided that they needed to establish a Review Board to monitor ESHT's plans for quality improvement in response to the CQC's findings. It was agreed that substantive work on this would not commence until the CQC had published its follow-up report.

6. The follow-up CQC report was published on the 22nd September 2015. The CQC found that ESHT services had got better in some respects, but that in a number of the most significant areas of concern there had been little or no improvement or even a worsening performance. By this point, both the Chair and the Chief Executive of ESHT had resigned and an interim senior management team led by acting Chief Executive Richard Sunley was in place. The TDA had also appointed a Director of Improvement, Maggie Oldham, to work with the trust. ESHT, the CQC and the TDA discussed the second inspection report with HOSC members at the 1st October 2015 HOSC meeting.

The Review Board

7. Given the scale and importance of this issue, it was decided that the whole committee should have the opportunity to take part in reviewing ESHT's quality improvement planning. It was therefore agreed that the ESHT Quality Improvement Scrutiny Review Board should include all HOSC members. Sitting under this Review Board would be five 'sub-committees', each exploring one of the key service areas identified by the CQC: surgery, maternity, patient records, outpatients and pharmacy.

8. In addition to focusing on these service areas, the CQC inspection reports also found serious flaws in ESHT's leadership and organisational culture. Since these cultural issues typically cut across service areas, HOSC members agreed that they should be explored by the Review Board as a whole rather than by the sub-committees. The Review Board met in plenary session on 30th July 2015 to determine how to tackle the project. Members agreed that they would focus on the trust's Quality Improvement Plan.

Quality Improvement Plan (QIP)

9. Following an inspection, NHS trusts are required to develop a Quality Improvement Plan (QIP) in response to the CQC's recommendations for improvement. QIPs typically take the form of a RAG (red, amber, green) performance report, listing progress against a series of actions. QIPs are public documents and should be regularly updated and reported to the trust's Board.

10. ESHT had produced a QIP in response to the initial (March 2015) QCQ inspection report. However, HOSC members had concerns as to whether this plan was ambitious enough to deliver the scale of improvement required, and whether it demonstrated that trust leaders fully accepted how poor performance in some areas actually was.

11. The QIP was substantially revised following the publication of the follow-up CQC inspection report and the establishment of a new senior management team at the trust. This new QIP was appreciably more comprehensive and challenging, recognising that ESHT had to make very significant quality improvements. Whereas the initial QIP seems to have been largely the construct of senior managers, the revised QIP actions were developed with the active input of relevant departmental staff and it consequently captures much more front-line intelligence around how to achieve service improvements. HOSC members are more confident that the current QIP reflects the findings of the CQC inspections and represents a robust blueprint for improvement.

12. It should be noted that the QIP represents only one aspect of ESHT's quality improvement work, albeit a very significant one. There are other quality improvement work-streams which are distinct from, but aligned with, the QIP.

Sub-Committees

13. HOSC members volunteered to sit on the five themed sub-committees of the Review Board. Membership was:

- **Surgery Sub-Committee:** Cllr Angharad Davies, Cllr John Ungar (Eastbourne Borough Council representative)
- **Maternity Sub-Committee:** Cllr Angharad Davies, Cllr Ruth O'Keeffe MBE, Julie Eason (Community Sector representative)

- **Pharmacy Sub-Committee:** Cllr Bob Standley, Cllr Bridget George (Rother District Council representative)

- **Patient Records Sub Committee:** Cllr John Ungar (Eastbourne Borough Council representative), Cllr Alan Shuttleworth, Cllr Bob Standley

- **Outpatients Sub-Committee:** Cllr Sam Adeniji (Lewes District Council representative), Cllr Ruth O'Keeffe MBE, Cllr Bridget George (Rother District Council representative), Cllr Alan Shuttleworth, Cllr Frank Carstairs.

14. Every sub-committee held a planning meeting, agreeing priorities and identifying potential witnesses. Each of the sub-committees subsequently met with key ESHT staff. All the sub-committee members were keen to talk to a range of operational staff including medical staff and technicians rather than just with senior managers. It was also decided that, whenever possible, evidence-gathering meetings should take place at The Conquest or Eastbourne District General hospitals, both so there was minimal inconvenience to trust staff and so sub-committee members had the opportunity to talk to people in situ and to see hospital facilities for themselves.

15. In all, the Review Board sub-committees spoke to more than 40 ESHT staff representing a wide range of services. Review Board members were struck by the evident pride that many ESHT employees take in their teams' achievements, and by the shared enthusiasm to further improve services. The Review Board would like to thank all those who took the time to contribute.

The Purpose of the Review

16. The ultimate aim of ESHT's quality improvement work is to transform the trust from ***inadequate*** to ***outstanding***. This is a considerable task. Several of the biggest improvement plans require significant structural investments, such as the creation of a new patient records depot in Hailsham. Many of the cultural changes required will not happen overnight either: staff who are afraid to raise safety issues will take time to learn to trust leaders, even if it is genuinely the case that the culture of the trust has changed for the better.

17. It was therefore never intended that the Review Board should come to a view on whether ESHT has succeeded in dealing with all the quality issues identified by the CQC. Rather, the Review Board wanted to be assured of three things:

- Firstly that ESHT's leaders recognise the scale of the challenge facing them;

- Secondly that there is a serious, long-term commitment to improve quality;

- And thirdly, that the actions ESHT is taking are commensurate with the magnitude of the changes that are needed.

None of these can be taken as a given – and it is not at all clear that an objective observer would have felt that ESHT was in a position to deliver any of them following the publication of the first CQC report in March 2015.

18. This report is intended to assist the CQC and the TDA in carrying out their regulatory roles by detailing whether HOSC members have confidence in the leadership of ESHT and in the trust's direction of travel. However, some of the ESHT quality improvement projects may well inform the HOSC's future work programme also.

Organisational Culture

19. Both the March and September 2015 CQC inspection reports rated ESHT as ***inadequate*** in the ***well-led*** domain. Problems identified by the CQC included a disconnect between the trust board and front-line workers; poor communication with key stakeholders; a climate in which staff were afraid to speak out about safety concerns; and a refusal by senior managers to deal with or even acknowledge serious and systemic performance issues.

20. It was evident that the CQC had limited faith in ESHT's most senior leaders, a view that was shared by a number of key stakeholders. The appointment of Sue Bernhauser OBE as acting Chair and Richard Sunley as acting Chief Executive was a welcome move therefore; as was the appointment by the TDA of Maggie Oldham, albeit only for four months, as Improvement Director. HOSC members noted an immediate change for the better in relations with ESHT following these appointments, and ESHT's interim senior leadership team should be commended for the way in which they have managed the trust under very difficult circumstances.

21. The ESHT Quality Improvement Review Board met with Richard Sunley, the ESHT acting Chief Executive; Monica Green, Director of HR; and Alice Webster, Director of Nursing, on the 17th November 2015 to talk about organisational culture. The Review Board focused particularly on: complaints (e.g. how complaints information is used to improve services); incident reporting (how staff are encouraged to report incidents and how learning from incidents informs service improvement); the Friends & Family test (i.e. what percentage of users would recommend the trust to their friends or family); staff satisfaction (particularly as expressed in the annual NHS staff survey); sickness absence (i.e. as an indicator of stressed or disengaged staff); bullying & harassment; and recruitment/staffing.

Staff Satisfaction

"We saw a culture where staff remained afraid to speak out or to share their concerns openly. We heard from several sources about detriment staff had suffered when they raised concerns about patient safety." (CQC Sep 15 Summary Report p3)

"The trust board continues to state they recognise that staff engagement is an area of concern but the evidence we found suggests there is a void between the Board perception and the reality of working at the trust. At senior management and executive level the trust managers spoke entirely positively and said the majority of staff were 'on board', blaming just a few dissenters for the negative comments that we received." (CQC Sep 15 Inspection Summary)

22. The March 2015 CQC inspection reports show ESHT as an organisation with a worrying disconnect between senior leaders and front-line workers; with poor staff engagement; and with a culture in which bullying and harassment are tolerated and where there is a perception that people voicing legitimate concerns about safety or efficiency are likely to be punished rather than supported.

23. Despite this being a headline finding in the March reports, the September 2015 reports found that the problems still persisted and that senior leaders seemed to be in denial about the level of disconnection between board and ward. The CQC stated that: *"there remains a clear disconnect between the views of the staff and those of the executive leadership. We saw examples where the staff view was a clear contradiction (more negative) from the senior leadership's position. We remain convinced that the executive leadership is not acknowledging this as a significant challenge for the future of the trust."* (CQC Sep 15 Summary Report p20)

24. This breakdown in relationships has been reflected in recent staff surveys. As the CQC notes: *"the most recent NHS staff satisfaction survey showed the trust performing badly in most areas. It was below average for 23 of the 29 measures, and in the bottom 20% (worst) for 18 measures."* (CQC Sep 15 Summary Report p3) ESHT staff survey results can be found here: **www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results/**

25. Richard Sunley acknowledged that there are important issues to be addressed here and detailed some of the trust's actions to date:

- To improve the management skills of middle managers such as Clinical Leads, ESHT is providing several **Leadership Programmes.** These include a 3 day Senior Medical Team Leadership Programme run by the Faculty of Medical Leadership; a Master class for Engaging with Staff by Sally Cray Associates; and an Out of Hospital Services Leadership and Change Development Programme. These programmes will help to ensure that clinical leads have the skills to engage with individuals and teams – in some cases clinical leads have been recruited for their medical prowess and not their leadership skills.
- The trust has set up **listening events** for staff. These include events where staff say what they want and managers endeavour to provide it for them: for example, staff have stated that often they do not understand or follow procedures regarding the reporting of risk and the trust is now working on providing them with the relevant training. There are also separate listening events for staff to raise concerns about undermining behaviours in their workplace.
- ESHT's Board and senior managers meet regularly for **leadership conversations** where they look at, amongst other things, examples of best practice in the trust that can be spread to other areas. For example, new governance and staff engagement activities in the Surgery Department have been disseminated to other areas.
- Richard Sunley and other board members attend and listen at **staff forums and open sessions** every week throughout the trust.
- The trust has launched a **'You Said We Did' Campaign** that tells staff what the trust has done about their suggestions and complaints. The campaign is publicised in the form of posters, newsletters, departmental meetings, and direct conversations with staff.
- There has been an increased emphasis on recognising the stresses that staff are subject to. Resilience training has been successfully piloted and will be rolled-out across the workforce. 'Schwartz Centre Rounds' have also been introduced. These are structured monthly forums, supported by a psychologist, that enable staff to come together to share and reflect on their experiences and offer mutual support.

26. ESHT expects these measures to have a positive impact across the trust. However, these improvements are not likely to show in the 2015 Staff Survey, since positive changes will take some time to spread through the organisation and be felt as improvements by staff.

27. This issue was also explored with trust staff at a number of the sub-committee meetings, and the consensus was that there has been a significant recent shift away from 'top-down' management to a more genuinely inclusive approach. For example, the pharmacy leadership group has been enlarged, bringing in a wider range of staff, with additional workers regularly invited in to contribute to specific discussions. The sub-committee was also told that the pharmacy actions in the QIP developed in response to the initial CQC report had been very top-down, with little direct involvement of pharmacy staff. In contrast, the revised pharmacy QIP following the second CQC report was developed by the pharmacy service itself, utilising the experience and expertise of front-line workers.

28. Similarly, the maternity sub-committee was told that all staff in maternity units have been invited to contribute to the current quality improvement process, and front-line staff input has already been instrumental in the planning and design of the new birthing room at the Conquest.

29. ESHT has also recently appointed a 'Speak Up Guardian', who will raise staff concerns with the trust's leadership. Workers will be signposted to the Guardian by 'Speak Up Supporters', who will include all the ESHT Trade Union representatives. This is a concept that was successfully piloted at Mid-Staffs Hospital Trust. It enables workers to communicate concerns to leaders without having to do so via their line-managers.

Sickness Absence

"Low staffing levels were compounded by high and increasing sickness levels. The papers presented to the Board dated 25 March 2015 showed a trend of increased sickness from August 2014 to January 2015. The annual sickness rate in January 2015 was 4.8% against a target of 3.3%." (CQC Sep 15 Summary Report p23)

30. The Review Board was concerned with the issue of sickness absence both because of the number of absences and because sickness rates are widely seen as a useful proxy measure of how well an organisation supports its workers. For reference, according to the Carter report on Operational Productivity and Performance in English NHS Acute Hospitals, the range of sickness and absence rates across English hospital trusts is 2.7 – 5.8%, with a median of 4.1% (Carter, 2016 p17).

31. The Review Board heard that the trust has recently introduced a Health & Wellbeing training programme for staff. The programme includes support for weight loss. This has initially been targeted at the departments with the highest sickness rates, and its success will be measured in terms of sickness rate reduction. This is a welcome development given the CQC's criticisms of ESHT Occupational Health support. Trust sickness reporting arrangements have also recently been revised after consultation with staff, and in-year data shows sickness rates reducing across the trust. It is too early to say whether these improvements are sustainable.

Bullying and Harassment

"We had a larger than expected number of staff contact us during and subsequent to this inspection visit who were not prepared to reveal their identity until we could assure their confidentiality but who shared detailed information about the way they had been treated as a result of raising concerns. We found a real culture of blame and holding people to account for things they had very little control over. This remained unchanged since the previous inspection." (CQC Sep 15 Summary Report p25)

ESHT must: "**Undertake a root and branch review across the organisation to address the perceptions of a bullying culture, as required in our previous inspection report."** (CQC Sep 15 Summary Report p30)

32. ESHT staff reports of being bullied are higher this year than in previous years. However, the Review Board was told this is more likely to be because staff now feel more confident at reporting incidents than because bullying has increased. When the Review Board met with them, the trust wasn't in a position to report back on the results of its review of bullying and harassment. This is an important issue, and a very challenging one: when staff in an organisation believe that bullying is tolerated it can take a long time to convince them it is not, even if leaders have genuinely adopted a no tolerance policy.

33. In discussions with the trust, and even with the new leadership team, it has not always been clear to HOSC members that ESHT's leaders unequivocally accept that there has been a serious and widespread culture of bullying in the trust rather than just a "perception of bullying." The CQC inspections found clear evidence of both. This remains an issue of concern: ESHT is unlikely to make positive changes to its culture without first recognising that bullying has been wide-spread.

34. That bullying and harassment should be the consequence of staff speaking out on safety issues is of particular concern. NHS workers have both a right and a duty to raise concerns about patient safety or excessive workloads; and they must be actively encouraged and supported to do so, even if what they report is uncomfortable or embarrassing for their employer. There is a very considerable cultural shift required here, but an essential one if ESHT leaders are serious about quality improvement. ESHT has recently launched a 'values' programme, which involves all staff embracing the values of: ***working together; engagement & involvement; respect & compassion; and improvement & development***. A key part of this must surely involve requiring managers to support workers to share their safety or workload concerns.

Internal Communication

"Overall the trust was amongst the bottom 20% of all trusts in England for staff engagement. Only 18% of staff reported good communications between managers and staff against a national average of 30%." (CQC Sep 15 Summary Report p3)

35. Engaging with the whole of ESHT's workforce presents considerable challenges, particularly as not all staff have ready access to email or to the trust's intranet pages. This is made more difficult by the fact that the trust only has a very small Communications team – the size of the team seems indicative of the importance that ESHT has historically given to effective communication. ESHT has applied for TDA funding to expand this service as part of the trust's plans to emerge from special measures.

External Communication

"There remained a poor relationship between the board and some key community stakeholders. We found the board lacked a credible strategy for effective engagement to improve relationships." (CQC Sep 15 Summary Report p3)

36. ESHT's communication with key stakeholders, including the HOSC, has long been problematic. The CQC identified a breakdown of relations with stakeholders following the often controversial reconfigurations of surgery and maternity services. For the CQC, whilst ESHT recognised that there had been a deterioration of trust with community stakeholders, *"senior executive officers remained convinced that the root cause of the trust problems was malicious objection to the reconfiguration, rather than any failings by the trust board and executive team. This was not what staff and local people told us during and subsequent to the inspection."* (CQC Sep 15 Summary Report p21)

37. The CQC further found that: *"when we spoke with senior staff about the communication strategy post reconfiguration they acknowledged that it wasn't working but said they were going to continue with it regardless of the lack of effectiveness."* (CQC Sep 15 Summary Report p21)

38. The HOSC has also struggled to get the previous management regime at ESHT to talk candidly about the scale of the problems at the trust. For example, there was a HOSC meeting on the 26th March 2015 (the day before the publication of the first CQC inspection report) at which members considered ESHT maternity services following their

reconfiguration. Although ESHT contributed to this item, there was no mention of the significant problems with the service that had been identified by the CQC inspectors. (The second CQC inspection in March 2015 found a number of these problems had persisted, so it was not the case that the CQC report referred to a situation at the time of inspection in September 2014 that had been resolved by March 2015.) Whilst detailed discussion of the contents of the CQC report was quite properly embargoed until its publication, the general failure to acknowledge that all was not well with maternity services fell far below the level of candour to be expected of NHS trusts reporting to a HOSC.

39. The acting ESHT Chief Executive, Richard Sunley, and his leadership team have engaged much more positively with the HOSC than their predecessors, and this relationship at least has considerably improved. ESHT managers and clinicians have also been supportive of the work of the ESHT Quality Improvement Scrutiny Board.

Complaints

"The trust does receive a higher than average number of complaints for its size although numbers of complaints have fallen over the last two years. We found a complaints system that gave both poor support for people who wished to raise a concern, and concerns on how the trust handled complaints." (CQC Sep 15 Summary Report p4)

40. The Review Board was concerned with the way in which the trust responded to complaints. ESHT leaders acknowledge that the trust had not been responsive enough, and in recent months there has been investment in the complaints function, including the appointment of a new Complaints Manager, additional staff and funding for broader workforce training in dealing with complaints. There is also an increased focus on analysing complaints data to drive service improvement – for example by identifying and offering training to staff who have had multiple complaints made against them.

41. Systems are also now in place to ensure that all complainants are contacted by phone to ensure that their complaint has been dealt with and to enquire whether they have additional concerns.

42. It is not yet clear whether these measures have significantly improved the situation. Complaints have actually risen in recent months, although the number of complaints that have been re-opened because they have not been adequately resolved has reduced significantly which may indicate better performance.

Friends & Family Test (FFT)

43. The FFT is a survey which aims to ask all patients whether they would recommend an NHS service to their own friends or family. ESHT is not an outlier in terms of its FFT scores: 95% of those using in-patient services who responded to the survey in April 2015 said that they would recommend the trust to their friends & family. Some FFT feedback to the trust has led directly to practical improvements – for example complaints about the (unavoidable) noise in wards at night from electronic monitoring equipment led to the provision of ear-plugs for those patients who required them.

Incident Reporting

"**Staff remained unconvinced of the benefit of incident reporting, and were therefore not reporting incidents or near misses to the trust. The trust was not able to benefit from any learning from these. This position had not improved."** (CQC Sep 15 Summary Report p3)

"Within the trust, we did not see a cycle of improvement and learning based on the outcome of either risk or incidents." (CQC Sep 15 Summary Report p3)

44. Hospital staff are required to report a wide range of clinical incidents. This includes a nationally prescribed set of 'serious incidents'. There is also a consensus that high quality incident reporting should go well beyond serious incidents, with workers being encouraged to report even relatively low level 'no harm' incidents so that the organisation can learn from them.

45. As the September 2015 CQC report acknowledges, National Reporting and Learning Service (NRLS) data suggests ESHT is a good (i.e. high) reporter of safety incidents (CQC summary report p10). Nonetheless, the CQC identified significant concerns with incident reporting, particularly in terms of how data on incidents was being used to drive improvement. The CQC stated: *"incident reporting, the feedback from incidents and the learning by both the organisation and individual staff was not as good as it should have been. We did not see evidence of learning; nor did we see a systematic approach to sharing information or a culture to support this."* (CQC Sep 15 Summary Report p10)

46. Since March 2015 there have been a number of initiatives to improve performance in this area:

- The trust has introduced a phone line that enables lower grade staff to report incidents without having to do so via their line-manager.
- There is a weekly patient safety summit involving all clinical leads and head nurses at which Level 3, 4 and 5 incidents (moderate, significant and catastrophic) as well as near misses are discussed in detail. This meeting is led by the Director of Nursing and a Clinical Director. In addition, less serious Level 1 and 2 incident reports are randomly reviewed by senior clinicians to check whether they have been appropriately graded.
- The average time taken to report incidents at the trust has fallen from 6 to 2-3 days (there is still work to be done here as the national target is for all incidents to be logged within 48 hours). The trend for incident reporting across the trust is also upwards, with 250 additional incidents reported this year compared to last.
- The CQC was particularly critical of incident reporting in the surgical departments, and the trust has commissioned an external review of this.
- Poor incident reporting can also be a consequence of having too few administrative staff to enter the required data. ESHT is currently recruiting an additional Band 4 administrator for each clinical unit, in part to improve incident reporting rates.

Staffing/Recruitment

"We saw low staffing levels that impacted on the trust's ability to deliver efficient and effective care." (CQC Sep 15 Summary Report p4)

47. Staffing was identified by the CQC as a concern in a number of services across the trust. ESHT has long term issues with recruiting workers, as do many NHS trusts across England – it is clear that there are serious national staff shortages, especially in terms of nurses and of medical staff in certain specialities. However, some trusts have been much more successful than others in recruiting and retaining staff and there is a good deal that NHS organisations can do to increase their staffing levels by adopting best practice.

48. NHS trusts are increasingly seeking to recruit staff from abroad and ESHT has recently been successful in recruiting 14 nurses from the Philippines. The trust plans to recruit from Spain in the near future. Although visa restrictions have recently eased, mass foreign recruitment remains a complex process, and recruiting suitably qualified people with fluent English is a challenge. When foreign nurses are recruited they are typically initially employed as Healthcare Assistants until they can demonstrate their professional competency and English skills in a real work environment.

49. ESHT is actively examining whether it might make sense to re-design some job roles to ease recruitment pressure. For example, if some roles currently undertaken by doctors could be re-assigned to physician's assistants or to ward support workers then this might mean that fewer hard-to-recruit doctors need to be employed. This initiative is part of a national programme supported by Health Education England.

50. There has been a surge in demand for nursing staff across England following the 2013 Francis report on Mid-Staffordshire NHS Foundation Trust, which made challenging recommendations for safe staffing levels. In the short term most trusts have sought to employ agency workers to cover the emerging staffing gap. The use of agency workers to cover staff shortages significantly increases NHS trust staffing costs. It can also impact upon quality if the agency staff used are not fully familiar with trust policies, procedures and working practices. The September 2015 CQC summary report notes that: *"there was a high reliance on agency staffing in surgical services. There was no documentary evidence to show temporary staff had received induction or were made familiar with the area".* (p13)

51. ESHT has developed a 'bank' of trust staff willing to work additional shifts. Bank staff are typically paid at lower rates than agency staff (and no agency fees are involved), and they are already familiar with ESHT working practices, so they generally represent a better option to deal with short-term staff shortages. However, many workers choose to sign-up for agencies rather than the bank because the pay is better, so there is no immediate prospect of eliminating reliance on agency workers (and in fact the ESHT agency spend has increased very significantly over the past year, in line with many other acute trusts). Ongoing Government attempts to cap agency costs may have a positive impact here.

52. The relatively small size of the Conquest and Eastbourne District General Hospitals also means that it has been historically difficult to attract or to retain training-grade medical staff: doctors typically prefer to train at larger hospitals where there is a more varied case load and a greater opportunity for hands-on learning. The recent reconfigurations of key services may help address these issues to a degree, and the Review Board was told that the number of trainees has increased as a consequence of ESHT being able to offer more direct supervision. Nonetheless, attracting training-grade staff is likely to remain a challenge going forward.

53. Trusts that struggle to recruit staff need to make a particular effort to ensure that their staff retention is good, and that staff who leave the trust are actively encouraged to return. The maternity sub-committee was told that the trust has a high rate of returners, which managers believe is indicative of a positive working culture. Recently the trust has also

persuaded some midwives to return to practice, filling vacancies in a particularly challenging area. This is all positive, although the turn-over of staff is relevant here also: retaining staff in the first place is a better option than persuading previous employees to return.

54. The current staffing position at ESHT seems relatively positive. However, it seems unlikely that NHS recruitment problems will ease significantly in the near future, especially in the service areas where there are national shortages of suitably qualified staff. There are particular problems associated with recruiting in the South East of England, where living costs are higher than the national average, but salaries are not (other than in London). It is also typically more difficult to recruit to smaller hospitals, which offer fewer opportunities for career development than do larger units such as the teaching hospitals in London or Brighton. Staffing is likely to remain a problem for ESHT therefore, and it is important that the trust continues to learn from national and regional best practice and to develop its own initiatives to entice workers to Eastbourne and Hastings.

Review Board Sub-Committees

Pharmacy Sub-Committee

Cllr Bob Standley; Cllr Bridget George (Rother District Council representative)

55. The Review Board pharmacy sub-committee visited Eastbourne District General Hospital (EDGH) on the 15th January 2016 to meet with pharmacy staff, tour the pharmacy department and visit a hospital ward to see how drugs are stored and supplied. The **Pharmacy Team** told the sub-committee that:

56. Pharmacy services were due to be restructured in 2014, but this was put on hold because community healthcare in the High Weald Lewes Havens Clinical Commissioning Group area was being re-tendered (the contract, formerly held by ESHT, was eventually awarded to another NHS provider). The sub-committee was told that this unsettled workers and meant that plans to address staffing shortages were delayed.

57. Pharmacy staffing issues were added to the trust risk register in 2012, but were removed by the then Chief Pharmacist in 2014, although there were still significant unresolved establishment issues. Pharmacy staffing was not communicated to the CQC as a risk prior to its initial September 2014 inspection. However, the CQC immediately recognised that staffing was an issue, and also identified a number of issues with medicines management. The Chief Pharmacist did not consider these issues to be significant. The former Chief Pharmacist has now left and the current pharmacy leadership team thinks that the CQC comments about medicines management were fair.

58. CQC concerns about staffing levels were also reasonable, although the timing of the visit was unfortunate in that the trust had recently recruited an additional six pharmacists, but they had not assumed their posts at the time of the first inspection.

59. Relatively little had changed by the time of the second CQC inspection. The initial pharmacy QIP was very top-down, and didn't utilise the expertise of front-line staff. There was some reluctance at a corporate level to acknowledge that the department needed to make significant changes.

60. Subsequently, there has been a step-change in the pace of improvement. The revised QIP following the second CQC inspection was developed with the input of all pharmacy staff. Progress is monitored weekly, and currently all QIP actions have been completed or are on target.

61. The Pharmacy Team said that recruitment was also progressing well. Rather than conforming to the traditional service structure, pharmacy recruitment policy now attempts to attract staff with the particular skills to meet service priorities and to fill the gaps identified in the CQC inspections – e.g. a lead clinical unit pharmacist for Women's and Children's services who can help with the provision of medicines management leadership within that clinical area.

62. The lack of corporate grip on medicines management issues is being addressed through the development of a new set of key performance indicators (KPIs) which will translate highly technical data from audits of controlled drug management, the safe and secure handling of medicines, and a drug chart audit. This will be presented as a KPI and set of quality measures that Board members will readily comprehend and that relates to the overall picture of medicines management and patient care within the Trust.

63. Internal pharmacy audit arrangements have been recently strengthened, with medicines management now being audited quarterly (rather than on an ad hoc basis), and controlled drug management audited quarterly rather than six monthly. Increased staffing resources have made this improvement possible.

64. ESHT has agreed a medicine safety thermometer CQUIN (Commissioning for Quality and Innovation payment) for 2015/16. This is nurse-led with all acute wards participating. It is intended to encourage greater matron awareness and ward autonomy in medicines management, making the point that it is part of everyone's job not just a pharmacy issue. The data is being used to analyse and support improvements within patient safety.

65. Corporate engagement with pharmacy has increased, both in terms of funding (e.g. for additional staffing and for the roll-out of Omnicell medicines storage cabinets across key wards), and via the inclusion of medicines management as part of the trust's internal CREWS (Caring, Responsive, Effective, Well-led and Safe) review process. ESHT is also increasingly recognising the key strategic role that pharmacy services have to play - e.g. in facilitating timely discharge or in minimising the nurse time spent on ordering and administering medicines, thereby helping the Trust manage staff shortages elsewhere.

66. There is an increased focus on medicines reconciliation (the process of ensuring that patients are taking appropriate medication – e.g. that their prescribed drugs are necessary and that they are actually taking the drugs as intended).

67. The CQC criticisms of supply to third parties have now been resolved, and ESHT no longer supplies to third parties.

68. Pharmacy currently operates a five day service, with on-call arrangements for out of hours and weekend working. Once quality improvements in the current service have been sustained, the aim is to develop a seven day service.

69. The Pharmacy Team has found engagement from the CQC and TDA to have been a positive experience. Both organisations have been very supportive, particularly in terms of the expert peer input from Lewisham & Greenwich NHS Trust. Making service problems public has meant that long-standing issues are finally being addressed. Managers expect the next CQC inspection findings to be much more positive and welcome further input from the CQC.

Maternity Sub-Committee

Cllr Angharad Davies, Cllr Ruth O'Keeffe MBE, Julie Eason (Community Sector representative)

70. The maternity sub-committee visited the Conquest Hospital, Hastings on the 8th January 2016 to meet with managers and clinicians and to tour the maternity and neonatal facilities. Key points made by witnesses from the Maternity Department included:

71. All departmental staff were invited to contribute to the development of the current QIP. Outstanding QIP actions are reviewed weekly at a meeting chaired by the Director of Nursing.

72. Ward security issues highlighted by the CQC have now been addressed – doors that were opened for ventilation have now been re-designed so that they can be partly opened to provide a breeze but not access to the wards.

73. CQC criticism of incident reporting had some foundation. Whilst serious incident reporting was robust, the investigation and learning process for minor incidents was less so. In the maternity unit there is now a daily consultant-led incident review, in contrast to the previous monthly round-up. Staff are encouraged to record all levels of incident on Datix, and there is a daily focus on a 'theme of the week' captured via incident reporting at each shift handover across all three maternity sites (the themes are updated weekly).

74. There is also a monthly newsletter on incidents. In addition, labour ward consultants cascade learning from incidents to junior doctors, and similar information is disseminated to matrons and midwives. There is also a quarterly seminar titled "Lessons Learnt" which is multidisciplinary and led by the Midwifery and Consultant Risk leads.

75. The CQC identified that ESHT was not following guidelines for pre-eclampsia. However, managers told the sub-committee that this concerned correctly documenting the activity that routinely took place rather than staff not undertaking the recommended activity. Witnesses explained to HOSC that there were no actual negative outcomes from the trust's actions here and that the problems identified by the CQC were being addressed.

76. Post-partum haemorrhage procedures were criticised by the CQC, although the sub-committee was told that a recent clinical audit suggests that no patient actually experienced inappropriate care. Sub-committee members were informed that ESHT has recently improved protocols around responding to this condition, and 'PROMPT' training (Practical Obstetric Multiprofessional Training) is being rolled out to staff.

77. In response to CQC criticism of maternity department management, the sub-committee was told that the trust has increased managerial capacity, freeing up manager and consultant time for a greater focus on strategic planning and on staff development. An externally-led development course for matrons has also been introduced, and has proved very popular.

78. Staffing is not currently far from establishment, but this may be a blip rather than a long term trend. The problems remain of recruiting to a small unit that is a relatively long way from London. There is a significant national gap in the supply of middle-grade doctors and has been since the introduction of the European Working Times Directive. This gap used to be filled by non-EU doctors, but this is no longer wholly the case.

79. The relatively small size of the maternity department makes it difficult to attract trainees, who will tend to opt for larger units, such as the London teaching hospitals (which give them more hands-on experience of a wide range of procedures, enhancing their employability). The trust has 60% of middle grade posts filled by non-consultant career grade doctors. There is a risk that junior doctors who are not seeking or unable to progress

to becoming consultants may stagnate, so ESHT offers a strong professional development programme, including the capacity to develop in sub-specialty areas.

80. The trust also uses simulations to provide training in scenarios that may rarely occur in a relatively small unit. The simulation programme has recently been revised and strengthened.

81. Midwife numbers are almost at establishment levels following recent successful recruitment rounds. Some midwives have been recruited from Spain and from Italy, and some have been persuaded to return to practice. The trust has also recruited midwives with specialities in bereavement, infant feeding, and perinatal mental health. The trust is seeking funding for specialists in teenage pregnancy and in substance misuse.

82. The HOSC sub-committee was informed that there are no significant capacity issues in the labour ward. Post-natal capacity has recently been increased, and a dedicated post-natal ward has been created. Capacity issues do arise in terms of post-natal beds, and these are managed by expediting the discharge process of mothers who are fit to be discharged. There are discharge bottle-necks – e.g. women who are ready to leave but who frequently have to wait for medical checks. A group of midwives has been trained to perform these checks to alleviate the bottle-necks and funding is being sought to train more midwives in these skills.

83. The trust permits women who are fit for discharge but who have babies in the special care unit to remain in post-natal beds where there is bed space.

84. Witnesses told the sub-committee that there is adequate ante-natal capacity. In line with national moves, the trust has recently introduced outpatient induction, although there has been relatively little demand for this service to date.

85. The sub-committee was told that the trust has responded to CQC criticisms of the cleanliness of wards by doing a good deal in terms of tidying and redecoration. Managers said that, while the wards were indeed tired and cluttered looking, it was debatable whether they were ever actually dirty. The sub-committee found the ward environment to be clean and less cluttered than on previous visits.

86. Managers are confident that the next CQC inspection will find that there have been significant improvements to maternity services, particularly in terms of recruitment and retention of staff, staff training, the physical ward environment, better incident reporting procedures and a more healthy corporate culture.

87. The sub-committee was informed that medical students have recently nominated paediatric consultants for Teaching awards, an indication of how improved the working environment now is.

Patient Records Sub-Committee

Cllr Alan Shuttleworth; Cllr John Ungar (Eastbourne Borough Council representative), Cllr Bob Standley

88. Patient Records sub-committee members met with patient records staff at EDGH on the 1st February 2016. Key points explained by **ESHT witnesses** were:

Background to the current situation

89. For some time prior to August 2014, the East Sussex Healthcare NHS Trust (ESHT) trust Board was aware of clear and significant risks within the Health Records service and

had added them to its risk register. The risks were not ignored but were not addressed in as timely a manner as they could have been: the Care Quality Commission (CQC) acknowledged in its September 2014 inspection that the Health Records service had developed a strategy but had not yet implemented it.

90. The trust board had been aware of some of the risks associated with the Health Records service in 2005 as the risk register from that time mentions those risks. These risks were not prioritised in the intervening years, perhaps because the NHS National Programme for IT was expected to address many of them (through the creation of a national electronic medical record database). Since the abandonment of the NHS National Programme for IT in 2011, ESHT has remained dependent on paper records – which must be moved physically between acute and community sites – to help with the assessment and treatment of patients.

91. The discussions around the impact of ESHT's clinical strategy did not include the clinical support units and, as a result, the health records service has had to "catch up" with the logistical challenges caused by the single-siting of stroke, general surgery and obstetrics in 2012.

92. The ESHT witnesses were confident that the combination of iFIT (electronic document tracking); the completion of the Operational Services Model for the records storage facility at Apex Way, Hailsham; and the implementation of the Electronic Document Management (EDM) will help to future-proof health records for the next 10 years.

Physical condition of the health records

93. Many health records are in a poor physical condition because:

- The materials that they are constructed from (paper and cardboard) degrade over time.
- The storage areas are inadequate across both acute sites.
- The single-siting of stroke, general surgery and obstetrics as part of the trust's clinical strategy means that records have to be moved between sites more frequently, increasing wear and tear.
- There is lack of appreciation from staff outside of the Health Records and Clinical Prep Teams that they are also responsible for ownership of the records.

94. Health records are repaired by a repair team at both acute sites on an ongoing basis However, the distribution of records to clinics is a priority and the team is often diverted from repairs to aid with distribution.

95. Alternatives to cardboard are very expensive, so the government funded EDM scheme, which will start to go live in October/November 2016, is the long term solution to paper records. Worthing Hospital and Queen Victoria Hospital (East Grinstead) will also be implementing EDM.

Temporary records

96. ESHT records the number of temporary records it creates on a weekly basis as a percentage of the total number of outpatient appointments. There is no national target for what percentage of temporary records are being used, but ESHT has set itself the target of 0.5% per week – amounting to approximately 80 patients. Another local trust has reported reducing its temporary files from 18% to 4% over the last 3 years as a major improvement. The weekly performance against the target of 0.5% is published in the trust Clinical Administration Dashboard.

97. There has not been a breakdown of the reasons for temporary medical records being used: for example, because the patient is on holiday in East Sussex. The data is collected manually and relies on honesty from those reporting the use of temporary medical records. The number of reported temporary records increased after the trust responded to the CQC's criticism of its low level of incident reporting. The number of reported incidents has reduced slightly since then, suggesting that the figures are now fairly reliable.

Health record storage

98. The number of health records held by ESHT grows at a rate of around 2,000 per month. There are approximately 700,000 records in storage, of which 400,000 are 'live'. There are strict legal rules for retaining, storing and destroying health records, which, combined with an aging population, means the total number of records continues to grow.

99. The current storage areas for live health records are not fit for purpose. Health records are currently dispersed across:

- The records library at the EDGH (built in 1976 and too small for current demand)
- Two satellite rooms in EDGH
- A leased warehouse in Apex Way, Hailsham
- A leased warehouse in Brampton Road, Eastbourne
- A records library at the Conquest Hospital
- Five satellite rooms in the Conquest Hospital.

100. Under the current arrangement, it is not unusual for a member of the Clinical Prep Team to find nine of 10 required health records in 30 minutes and spend 45 minutes finding the final record due to movement between the various storage locations or ESHT offices.

Health record transportation

101. Patients in East Sussex may receive appointments, follow-up appointments or inpatient care from one of 10 community or acute sites. The trust's courier service has been relied upon to deliver a patient's health records to the appropriate sites. However, the courier service is unable to prioritise health records or deliver them separately to other deliveries made between sites – which is an issue if the health record needs to be at the another site on the same day.

102. The Clinical Administration service has launched a pilot dedicated courier service for health records. The courier service comprises a single courier who transfers records between the two acute sites (via Bexhill Hospital) during the day – health records transferred in the evening still use the existing trust courier service. Since the pilot was implemented, there have been no instances of late deliveries or early pickups of health records. It is anticipated that this service will be maintained, and possibly expanded, in the next financial year.

Operational Services Model for Apex Way

103. In order to address the issues around storage and transportation of health records, and the health and safety concerns of staff, a new Operational Services Model is being developed. The proposed Operational Services Model involves the creation of one main records library at Apex Way, Hailsham, where all live records will be kept, with satellite offices at both acute sites. Brampton Road warehouse will be retained as back up for old

files. Apex Way is already leased and used for storing community records for the CCGs, for which ESHT receives reimbursement. In addition, proposals are being developed to expand the courier service so that it can deliver and return the files from Apex Way each day.

104. Other options were considered by management but were deemed unsuitable, for example:

- **The expansion of the existing records libraries in EDGH and Conquest** – the CQC report was critical of the lack of sufficient dignity provided to patients in the A&E and radiology departments. The estates strategy for ESHT recognises that these two departments need to expand in order to address this CQC concern. The space currently occupied by the records libraries in EDGH and Conquest Hospital is pivotal to creating additional clinical space and retaining essential on-site services.
- **The construction of new buildings on site at the acute hospitals** – this is beyond the available funding for the project.
- **Alternative sites** - Bexhill would be the ideal location for a single storage site, but managers told the sub-committee that there are no suitable locations in that town.

105. Given that Brampton Road is already used as a site for storing 'live' health records, the practice of moving files from an offsite location is already established. Furthermore, a travel survey indicated that 40% of ESHT's patients use both acute sites for their care, so, practically speaking, health records are often stored "offsite" currently.

106. Staff from the Conquest Hospital records library are concerned about the proposals: their job role is graded at band 2 and many of the staff are in the role partly because it provides a local job. They are also concerned about the safety of the site due to alleged higher incidents of crime.

107. The trust has undertaken several activities to try and ensure that the needs of staff are met and that it is a positive process, including:

- Staff side representatives and key union representatives sat on the project board for the planning stage of the project over the summer. The project board consensus was for the Apex Way site.
- Modelling work was carried out with staff to try and develop buy-in to the project by developing the specifications together.
- Assurance provided to staff that they would receive excess mileage reimbursement for four years for travel costs as this is written into their current contracts.
- Discussion about providing a mini bus service for staff – although they were not used often when provided for maternity staff following the reconfiguration of that service in 2014.
- A trust security adviser has undertaken a review and is satisfied with the level of security.
- An independent review of the proposals will also model how many staff will be affected by the changes – this will be reported to the trust board at a future date.

iFIT tracking

108. iFIT was introduced in August 2015 to replace the previous tracking facility which was part of the PAS Oasis system (the previous tracking system which was increasingly underused) and to address the three separate filing systems that existed as a result of the mergers of the two acute hospitals and East Sussex community healthcare services.

109. iFIT is based on location filing – not digital or alphabetical filing – meaning that shelves are divided into areas with their own unique RFID barcodes. A health records team member attaches an RFID barcode to the medical record and scans it and scans the RFID barcode on the shelf. When someone looks for the health record on the iFIT software, it will tell them the location. Records are not associated with one particular shelf, so can be put anywhere and as long as the two RFID barcodes are scanned, it can be easily recovered. At least eight or nine other NHS trusts now use iFIT.

110. Witnesses said that the other benefits of iFIT included:

- Sensors dotted around the trust and handheld scanning machines that emit a signal when near the desired medical record make it easy to find records that have gone missing.
- Temporary records can be tagged and then later merged with permanent records.
- Permanent records can also be split into volumes so that older information can be archived.
- Duplicate files can be merged if a duplicate is produced (rather than a temporary record) – which often happens in A&E when records cannot be found.

111. Medical records are also handled by ward clerks, medical secretaries, clinical clerks, and cancer pathway assistants (amongst others) who are all given 'wasp' scanners to scan the medical record when they receive it. The trust's philosophy is that using the tracking system is so easy that it must be used. The iFIT system can monitor who is not using it (as the scanners will show where the records have been) and recalcitrant staff can then be constructively challenged. It can also be used to track medical equipment and alert staff to upcoming clinics a week or more in advance.

112. 100,000 medical records have now been tagged with RFIDs in a rolling programme. Capital funding is being sought to systematically tag the other 400,000 medical records using a private organisation that specialises in health record tagging. This is currently being costed and is expected to take 8-12 weeks if funding is made available.

Other changes to Health Records team

113. The Health Records team was reorganised in the summer and this was further refined in early 2016 in order to give the team the ability to prepare health records two or three days in advance of clinics. Since the reorganisation, no deadlines for submitting health records to clinics have been missed.

114. An escalation procedure has been added for when medical records cannot be found. The local supervisor is alerted in the first instance; followed by the managers of the Clinical Preparation Team and the health records library; and then – if the records still cannot be found – the Head of Service and Assistant Director 48 hours before the clinic. In the past, there had been an acceptance that records had been lost and other teams were not informing health records that they were missing, for example, seven operations were cancelled in September 2015 due to missing notes – even though the majority must have been available two weeks before during the pre-operative assessment.

115. Management has carried out several initiatives to ensure that it is more open to suggestions and complaints, for example:

- A monthly newsletter is now sent to staff containing plaudits, a “did you know?” section, and general information about iFIT.
- Weekly management meetings are held to agree information to cascade to team meetings.
- Monthly team meetings are held, which senior managers also attend.
- In addition to the trust-wide Staff Forums, Clinical Administration also holds a monthly staff forum that senior managers attend, although staff attendance has been patchy in recent months.

Surgery Sub-Committee

Cllr Angharad Davies, Cllr John Ungar (Eastbourne Borough Council representative)

116. The surgery sub-committee met with ESHT staff and toured the surgical wards at the Conquest Hospital on the 25th February 2016. Key points from the **ESHT witnesses** included:

117. Sub-committee members were told that the reconfiguration of surgery caused a good deal of disruption and ill-feeling, some of which was captured in the CQC inspection reports. However, the rationalisation of services was essential to managing the consultant rota efficiently, to improving performance across a number of specialities, and to attracting and retaining high quality medical staff.

118. In the wake of reconfiguration, there are still cultural issues across the surgical department that need addressing. TDA interventions, following ESHT being placed under special measures, have focused on supporting the trust board rather than on supporting the surgical teams.

119. He sub-committee was informed that he reconfiguration of surgery and delivery of the trust clinical strategy included a programme of capital improvements, supported by a full business case. Around 80% of these improvements have now been delivered, which represents excellent progress given the general financial situation of the NHS and given the need for ESHT to use capital funding to address other issues identified by the CQC.

120. Current capital improvements are being undertaken whilst keeping the relevant wards open. This is challenging, but has been successfully achieved to date.

121. All on-call consultants now live within a 30 minute drive of the Conquest Hospital, or are happy to be based nearby (e.g. at a hotel) when on-call.

122. ESHT continues to provide surgical support at EDGH – a surgical registrar is always on site. However, demand for this support remains very low. In terms of the surgery still undertaken at EDGH, there are robust protocols in place for urology. There is a case for conducting more robust risk assessments of gynaecological procedures, with some higher risk operations potentially transferring to the Conquest hospital.

123. There is capacity on the surgical wards to cope well with surgery patients. However, the demand on general hospital beds means that surgical beds are routinely used for medical overflow. This inevitably makes it harder to run effective surgical services. It also means that relatively long-stay patients are occupying beds that are intended for very short

surgical stays (e.g. with no TV facilities) and being treated by nursing staff who are trained to support surgical rather than general medical patients. Some elective surgical procedures are being cancelled due to a lack of beds, and this is due to medical overflow, not to any lack of surgical capacity.

124. The sub-committee was told that here had been some issues with incident reporting in the department, but these have now been addressed. There is wide staff involvement in risk meetings: staff who report incidents now invariably receive feedback on the actions taken in response to their alerts; all staff can easily report incidents (agency workers are encouraged to approach permanent staff who will log incidents for them); and the number of low level incidents reported has significantly increased.

125. Analysis of mortality was identified as a weakness by the CQC. The HOSC sub-committee was told that here had always been robust analysis within the department, although the disruption caused by single-siting and the turnaround programme meant that this became somewhat ad hoc and activity that took place was not always fully recorded. This has now been addressed: there are regular mortality meetings and data on deaths is shared and analysed via specialist software.

126. Core surgical services already operate 7 days a week. However, key support services such as physio and ultrasound do not.

127. Managers maintain that discharge arrangements always functioned relatively well, but have been further improved in recent months, and that most discharge from hospital is fairly rapid. There are still problems with patients with co-morbidities (particularly in terms of dementia), and with patients who require minor adaptations to their homes before they can return to them. There is an effective fast-track process for patients with a terminal diagnosis.

128. All emergency trolleys have been renewed. Contrary to the CQC's assertions, the sub-committee was told that the trolleys had always been checked in preparation for the coming day. However, these checks used to be undertaken by night staff just before ward lights were dimmed at 11pm, which meant that there was no check recorded for the following calendar day. Checks now take place after midnight, meaning that should a trolley be inspected it will always show a check on the current day.

129. The CQC identified some medicine management issues within the department. These have now been addressed. The sub-committee was told that there was no actual patient harm arising from any of these problems.

130. Staffing is currently near establishment levels, although this remains a risk factor. It is important that recruitment is pro-active, whenever possible identifying future issues before they arise. In the longer term, co-working with local councils will be essential – e.g. in terms of the provision of more affordable housing for key workers.

Outpatients Sub-Committee

Cllr Alan Shuttleworth, Cllr Frank Carstairs, Cllrs Bridget George (Rother District Council representative), Cllr Sam Adeniji (Lewes District Council representative)

131. The Outpatients Sub-Committee met with ESHT staff and toured the Conquest Hospital outpatient facilities on the 29th February 2016. Key points raised by ESHT witnesses from the Outpatients Department included:

132. ESHT clinical administration was centralised in August 2014 as part of the trust's financial turnaround programme. However, the sub-committee was told that this was not as

well planned as it could have been and significant problems quickly emerged. It has taken a number of months to address these problems, and there are still some outstanding issues, but the trust now understands how the administration system works and where the stresses are. Previously it was not always clear why particular problems had arisen.

133. The majority of outpatient (OP) work is coordinated by the centralised administration service, although there are still services that manage their own appointments (e.g. radiology, physio). These areas have specific systems or processes that do not sit within the standard operating procedures for main outpatient clinics; however in the longer term the intention is for the centralised administration service to coordinate all general outpatient activity.

134. The trust works to achieve nationally set performance measures when appointing to OP clinics, such as the 18 week 'referral to treatment' target (RTT). The department also records achievement against a number of locally set milestones to help meet the national targets.

135. ESHT delivers OP appointments at several sites across East Sussex. Following clinical triage patients will always be offered the first available appointment whether or not this is at the location nearest to them. Patients may always opt to wait longer for an appointment at a location of their choice (other than for some specialist services which may only be available at one location). This can impact on RTT times, although there is a tolerance built into the target to accommodate this type of eventuality.

136. ESHT sends a reminder seven days before each appointment, and again 24 hours before. These are automated calls or text messages, except for patients who are over 70 who receive personal calls. Patient phone number information is not always available, and the team is active in soliciting and recording this information at all opportunities when speaking to patients.

137. In recent months there has been lots of work to analyse OP activity. For example, demand has been measured across a 12 month period and this information has been used to identify hot-spots and to allocate staff resources accordingly.

138. There has been a concerted effort to address the clinic DNA (Did Not Attend) rate, which was at around 10% (an outlier). This has proved successful and DNA is now 6.8%, which places ESHT towards the top quartile of acute trust performers.

139. Short notice (i.e. less than six weeks) cancellation of clinics was another problem for the trust. Analysis of the reasons has identified annual leave as a major factor (clinical staff are expected to give at least six weeks' notice of leave requirements, but have not always done so or the internal processes do not facilitate timely transfer of information). This type of analysis is an essential first step in addressing the problem of clinic cancellations, and recent months have seen steady progress on this front.

140. The trust has invested in an enhanced switchboard and new telephone system for the main appointment centre at the Conquest Hospital. The new system provides real-time data as well as capturing much more information about calls, and will help the trust better match staff resources to times of high customer demand. Since the new system was brought in, customer complaints about having to wait for calls to be answered have fallen significantly.

141. The outcome of clinic appointments (ensuring that follow-up appointments are booked and the appropriate patient pathway is recorded) remains a problem for the trust, although performance is improving. ESHT is aware of the causes and does hope to hit its targets here in the near future through a number of mechanisms. In the longer term, concerted improvement depends on the greater use of digital rather than paper-based systems.

142. The OP department had historically been considered low risk in terms of national cleaning standards and was consequently seldom audited. However, this risk assessment did not really take account of the range of work undertaken by OP, including minor surgery and other invasive procedures. OP is now considered high risk, which means that it is audited more frequently, helping support staff to deliver consistent high quality services. This also means that OP is better able to access ESHT's limited pot of capital funding in order to make improvements to estates.

143. The OP Department argued that CQC criticisms of aspects of OP cleanliness were not unreasonable, but didn't necessarily reflect the whole picture – e.g. equipment was regularly checked and cleaned, but this maintenance wasn't always properly documented. This has now been addressed: a 'fit to fly' checklist is completed at the start of each working today to ensure that all the required checks have been undertaken and documented.

144. OP now has much more robust processes in place than it did at the time of the CQC inspections and managers are confident that a future CQC inspection will have much more positive things to say.

Conclusion and Recommendations

How is ESHT Doing?

145. The Review Board started out asking three basic questions about the ESHT Quality Improvement process:

- Do the trust's leaders accept the scale of the improvement challenge?
- Is it evident that there is a serious and sustained commitment to change?
- And are the planned improvements commensurate with the magnitude of the task in hand?

146. It is clear that the interim leadership team has recognised the scale of the challenge that ESHT faces. However, at the time of this report a permanent trust Chair had only recently been appointed, and a Chief Executive has been announced but is not yet in post, so it is simply not possible to say what the attitude of the new leadership team will be. The Review Board hopes and trusts that the new ESHT leaders will build on the good work of Richard Sunley, the acting Chief Executive, and his team.

147. The Review Board has found a serious commitment to improvement. ESHT's interim leadership team has been open about the need to make fundamental changes to the way that the trust operates. The Review Board's sub-committees also saw that this commitment mirrored by senior clinicians and managers across a number of hospital departments. However, time will tell whether this commitment is sustained. It is obviously much more difficult to maintain tight focus across several years than over a few months, and it will take years to address some of ESHT's most entrenched cultural flaws.

148. The Review Board believes that the current Quality Improvement Plan (QIP) is much more robust and challenging than the plan developed under ESHT's previous leadership regime. Clearly the QIP actions alone will not move ESHT from ***inadequate*** to ***outstanding***, but the QIP does appear to provide a solid foundation for future improvement programmes to build on.

149. In summary, the Review Board is satisfied that ESHT's leaders understand that considerable improvement is required and that the trust is committed to and in a position to deliver significant and sustained quality improvement. There are important caveats to this support, because the trust is in the process of appointing a new leadership team; and also because we are still in the early stages of some of the most important improvement initiatives, particularly those which seek to transform elements of ESHT's organisational culture.

Recommendation 1: In the HOSC's view, ESHT's interim management team has shown that it understands the need for, is committed to, and is capable of delivering, sustained organisational improvement.

Monitoring Quality Improvement

150. The East Sussex Health Overview & Scrutiny Committee (HOSC) has a key role to play in monitoring ESHT's quality improvement actions over time. HOSC will consequently add the following issues to its work programme:

- Sickness Absence Rates (an annual report from ESHT on its work to reduce sickness absences, with data on sickness trends across the year)

- Bullying and Harassment (an annual report from ESHT on its ongoing work in this area. To include input from the Speak Up Guardian, data from the annual Staff Satisfaction Survey and feedback from ESHT's internal bullying & harassment review)
- Complaints (an annual report on complaints, to include information about the number of complaints and actions being taken to use complaints as a learning opportunity)
- Incident Reporting (a report to HOSC on the initiatives to improve incident reporting, to include: input from the Speak Up Guardian; information on the success of the staff incident phone line; data on performance against the national target of 48 hours for logging incidents; and information on the external review of incident reporting in the ESHT surgical department)
- Staffing and Recruitment (an annual report on ESHT staffing levels plus information on initiatives to improve recruitment and retention)
- 'Cashing-Up' rates (the rate at which outpatient follow-up appointments are booked following an initial appointment) a report-back to HOSC.

Recommendation 2: the HOSC will continue to monitor ESHT quality improvement, particularly in terms of: sickness, absence rates, bullying and harassment, complaints, incident reporting, and staffing and recruitment.

151. The Review Board has also chosen to make some more specific recommendations, based on the evidence gathered by Board members.

Capital Investment

152. A number of the improvements planned by ESHT, either as part of the QIP or as other quality improvement measures, are reliant upon capital funding. The most significant of these measures is perhaps the plan to renovate Eastbourne Midwife-Led Maternity Unit. This was a key element of the improvements promised as part of the reconfiguration of East Sussex acute maternity services (Better Beginnings). Other improvements that depend on capital funding potentially include the roll-out of Omnicell medicine cabinets across the trust and the digital tagging of patient records. However, pressure on national NHS capital funding and on individual NHS trust budgets means that the future of many capital projects is uncertain. We need to ensure that there is no ambiguity about local capital projects and that, where capital funding may no longer be accessible, other options are actively being pursued.

Recommendation 3: ESHT should report to the HOSC confirming whether funding for the promised Better Beginnings capital works and for any works that form part of the QIP has been secured. Should the predicted NHS or corporate funding no longer be available, ESHT should set out its alternative plans for securing key projects.

Pressure on Surgical Beds

153. The surgery sub-committee heard that a shortage of beds for general medical patients often leads to overflows into the surgical wards. This means that beds that ought to be used for very short-stay surgical patients are being filled with potentially much longer-stay medical patients. Not only is this a less than optimal use of a specialist resource, but it can mean that elective surgical procedures have to be postponed because no surgical beds are available. This inconveniences elective patients, even if there is no actual detriment to their health, and it also impacts on the trust's performance against the key 18 week 'referral to

treatment' target. This is an unacceptable situation, other than as a response to a truly unanticipated demand surge, and suggests that ESHT has too few general beds available, particularly during periods of higher demand. It is important that the trust develops a strategy to deal with this demand issue rather than just shifting the burden on to elective waiting times.

Recommendation 4: ESHT needs to develop a strategy to deal with general medical capacity demands without impacting on the performance of the trust's surgical units.

Leadership

154. The Review Board has heard a good deal about plans to improve leadership skills for fairly junior managers, but relatively little about the leadership skills of ESHT's leaders. However, the CQC identified serious failings at board level, particularly in terms of a disconnect between 'board and ward'. Although many former board members are no longer in place, there remains an evident need to address leadership at the highest level of the trust to ensure that these problems do not persist into the future. It would be helpful for the HOSC to get a picture of what kinds of senior leadership develop is being undertaken.

Recommendation 5: ESHT is asked to report to the HOSC on its plans for board development in response to the CQC's criticisms of trust senior leadership.

Strategic Risk Management

155. Most large organisations, including NHS provider trusts, maintain some kind of risk register in order to identify, quantify and mitigate emerging strategic risks. It ought therefore to have been the case that ESHT knew in advance about the major issues identified in the CQC inspection reports and had plans to deal with these issues. However, it is evident from the CQC's findings and from the Review Board's investigations that the trust's risk procedures were not robust enough to capture and address some major strategic risks at a relatively early stage.

156. This was certainly the case with patient records, where the deterioration of the system was identified as a risk, but never adequately addressed. The risk of under-staffing across a number of departments also seems to have received inadequate attention, with a reactive rather than pro-active approach to recruitment. Whilst it is obviously easy to be wise about risk in hindsight, the failure to appropriately manage so many risks does suggest that ESHT's risk management system is in need of an overhaul.

Recommendation 6: ESHT is asked to report to the HOSC on what it is doing to ensure that the trust's system of strategic risk management is fit for purpose.

Hospital Discharge

157. Ensuring that patients who are medically fit to be discharged are in fact able to leave hospital in a timely manner is one of the most important challenges facing local health economies. Timely discharge maximises the beds available for new patients, as well as minimising inconvenience to patients and their families. Given how difficult it is to provide additional beds at many hospital sites, more efficient use of the current beds may be the best available method we have to manage increasing demand. Discharge can be an involved process, particularly for frail patients who require a complex package of care in order to return to their homes. This is typically a multi-agency problem, and delays in discharge may be due to issues within adult social care or community NHS services rather than being the fault of hospital trusts.

158. However, while not all the levers of timely discharge are held by acute providers, some certainly are. For instance, a common national problem is caused by patients who are declared ready for discharge early in the day but who then have to wait many hours for their discharge medications. Although no single patient's discharge may be delayed for more than a few hours due to waiting for medicines, the aggregate impact may be very significant across a hospital if such waits are commonplace. This is particularly important when hospital capacity is stretched – as it is in ESHT, with medical patients regularly overflowing into surgical beds.

Recommendation 7: ESHT is asked to report to the HOSC on what it is doing to ensure that hospital discharges are not unduly delayed by waits for take-home medicines or other factors within the control of the trust.

Incident Reporting and Complaints

159. The CQC criticised the way in which ESHT dealt with and learnt from staff incident reporting and also the way that the trust processed and learnt from customer complaints. These issues are now being addressed via the trust QIP and it appears that much more robust systems have been instituted, although it may be some time before we see a clear improvement in performance. Review Board members welcome these moves, but are particularly interested in the intersection of incident reporting and complaints.

160. It is evidently not the case that every incident that staff record will lead to a complaint: many incidents that cause no harm will never even be noticed by patients or their families. Equally, not every complaint links to an incident: some complaints may be ungrounded; others will be about issues such as staff behaviour or cancelled appointments rather than about a clinical 'incident' as such.

161. However, there will obviously be some potential cross-over between incidents and complaints: some incidents will have resulted in a complaint; some incidents will not, but would present reasonable grounds for complaint; some complaints may allege that an incident took place when staff have not reported anything. There is therefore a good deal to be gained from a comparative analysis of incidents and complaints. At the very least, cross-checking complaints against incidents should provide some assurance that the incident-reporting system is functioning properly. One would presumably expect that the great majority of complaints arising from 'incidents' will have been logged as incidents by staff at the time they occurred; and if this has not taken place it may suggest that incident reporting within a particular service is not as good as it might be.

Recommendation 8: ESHT is asked to report to HOSC on the measures it is taking to cross-reference the trust's incident reporting and complaints data.

Seven Day Working

162. The NHS is currently committed to moving from five to seven day working. Whilst it is not always clear what such a move would entail, and whilst a number of services already operate on something like a seven day model, there are nonetheless some obvious hospital services that will need to be redesigned to fit a seven day model. For example, the Review Board was told that further significant efficiencies in the pharmacy department will require the adoption of a seven day working model. Similarly, whilst surgical services already operate across seven days, some key supporting tools such as ultrasound scans and a full range of physio services do not. The HOSC would welcome early sight of ESHT's plans to move to a seven day working model.

Recommendation: ESHT is asked to report its plans to move to a seven day working model to the HOSC.

Appendix 1: HOSC/Review Board membership and project support

Committee membership

East Sussex County Council Members (Voting)

Councillor Michael Ensor (Chair)
Councillor Frank Carstairs
Councillor Angharad Davies
Councillor Ruth O'Keeffe (Vice-Chair)
Councillor Alan Shuttleworth
Councillor Bob Standley
Councillor Michael Wincott

District and Borough Council Members (Voting)

Eastbourne Borough Council
Councillor John Ungar

Hastings Borough Council
Councillor Sue Beaney

Lewes District Council
Councillor Sam Adeniji

Rother District Council
Councillor Bridget George

Wealden District Council
Councillor Johanna Howell

Voluntary Sector Representatives (Non-voting)

Ms Julie Eason (SpeakUp)
Ms Jennifer Twist (SpeakUp)

Project support – East Sussex County Council

Project Manager: Giles Rossington
Project Support: Harvey Winder

HOSC email: healthscrutiny@eastsussex.gov.uk
HOSC website: www.eastsussexhealth.org

Committee meeting dates

22 May 2015, 16 June 2015, 01 October 2015, 03 December 2015, 24 March 2016

Review Board meeting dates

16 June 2015, 30 July 2015, 03 March 2016

Witnesses providing evidence to HOSC and sub-committee meeting dates

17 November 2015: Organisational Culture

East Sussex Healthcare NHS Trust

- Richard Sunley, Acting Chief Executive
- Alice Webster, Director of Nursing
- Monica Green, Director of Human Resources

08 January 2016: Maternity

East Sussex Healthcare NHS Trust

- Michele Small, General Manager, Women, Children's & Sexual Health Clinical Unit
- Jenny Crowe, Head of Midwifery and Gynaecology
- Cathy O'Callaghan, Service Manager, Maternity
- Darren Langridge Kemp, Complaints and PALS Manager
- Dr Graham Whincup, Consultant Paediatrician
- Mini Nair, Consultant Obstetrician & Gynaecologist and Specialty Lead
- Fran Edmunds, Head of Nursing, Children's Services

15 January 2016: Pharmacy

East Sussex Healthcare NHS Trust

- Jonathon Palmer, Acting Chief Pharmacist
- Melanie Adams, Pharmacy Governance Manager
- Michelle Elphick, Theatres & Clinical Support General Manager
- Karen Strachan, Senior Aseptics Technician
- Rosie Furner, Acting Clinical Pharmacy Manager/Deputy Chief Pharmacist
- Emma Jones-Davies, Medicines Management Nurse/VTE
- Maria Andrade, Pharmacist Site Lead EDGH and Lead Clinical Unit Pharmacist for Theatres and Surgery
- Ben Clark, Pharmacist Site Lead: Conquest Hospital and Lead Clinical Unit Pharmacist for Specialist Medicine
- Kirsty Sully, Senior for Pharmacy Distribution
- Alan Hopkins, Dispensary Manager, EDGH
- Stephanie Collins, MI Manager
- Neville Sharma, Lead Antimicrobial Pharmacist
- Orla McCaffrey, Clinical Pharmacist and Beth Attwood, Medicines Management Service Lead Technician

01 February 2016: Patient Records

East Sussex Healthcare NHS Trust

- Liz Fellows, Assistant Director Operational Planning
- Jo Byers, Head of Clinical Administration
- Janice Horton-Wood, Health Records Manager - Projects
- Ciara Pooley, Clinic Preparation Supervisor
- Lesley Saunders, Health Records Manager – Operational

24 February 2016: Surgery

East Sussex Healthcare NHS Trust

- Miss Imelda Donnellan, Clinical Unit Lead, Surgery Clinical Unit
- Jayne Cannon, Head of Nursing Surgery Clinical Unit
- Matt Hardwick, General Manager Surgery Clinical Unit

29 February 2016: Outpatients

East Sussex Healthcare NHS Trust

- Liz Fellows, Assistant Director
- Jo Byers, Head of Clinical Administration
- James Blake, Performance Analyst
- Mike McKernan, Business & Governance Manager, Clinical Administration
- Sue Winser, Outpatient Matron - Conquest Hospital

HOSC Member visits

Conquest Hospital Maternity, 08 January 2016

Eastbourne District General Hospital Pharmacy, 15 January 2016

Eastbourne District General Hospital Patient Records, 01 February 2016

Conquest Hospital Surgery, 24 February 2016

Conquest Hospital Outpatients, 29 February 2016

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Appendix 2: Glossary of terms used in this report

CQC	Care Quality Commission (statutory regulator of health & social care)
The Conquest	The Conquest Hospital, Hastings
CQUIN	Commissioning for Quality & Innovation payment framework (local quality targets agreed by an NHS trust and CCG commissioners)
Datix	Specialist patient safety software system used for recording reports of clinical incidents, patient morbidity and mortality etc.
DNA	Did Not Attend (a patient failed to attend or to cancel an appointment)
EDGH	Eastbourne District General Hospital
EDM	Electronic Document Management – a system for digitally managing patient records
ESHT	East Sussex Healthcare NHS Trust
FFT	Friends & Family Test (after receiving NHS care all patients have the opportunity to say whether they would recommend the service to their friends or family)
HOSC	(East Sussex) Health Overview and Scrutiny Committee
iFIT	A system for electronically tracking patient medical records via barcode technology
Omnicell	A system for intelligently storing and dispending medicines on hospital wards
OP	Outpatients Department
QIP	Quality Improvement Plan (the action plan produced by NHS trusts in response to CQC inspection report recommendations)
RDIF	Radio Frequency Identification – a system for electronically tagging and tracking objects such as patient records
RTT	Referral To Treatment – the standard national 18 week target for elective procedures
Speak Up Guardian	An ESHT internal appointment whose job it is to communicate staff concerns to senior managers
TDA	NHS Trust Development Authority (oversees non-Foundation NHS trusts)